Pathways

GENERAL CONSENT TO CARE AND TREATMENT AND ACKNOWLEDGEMENT FORM

Case#	Name

PERMISSION FOR TREATMENT

I hereby authorize staff of Pathways to render any examination, prescription of medication, treatment procedures, or therapy rendered to _____ whose relationship to me is (check one) ❑ self, ❑ child, ❑ spouse, ❑ other (specify) _____ whether it be a face-to-face service or a Telehealth Service.

APPOINTMENT REMINDER CALLS

As a courtesy, Pathways places appointment reminder calls, texts, and emails to its consumers which includes leaving a message if the consumer is unable to answer the call. I agree to be reminded via:

PHONE CALL ❑Yes ❑No **TEXT MESSAGE** ❑Yes ❑No and/or **EMAIL** ❑Yes ❑No

ELECTRONIC HEALTH RECORD AND USE OF ARTIFICIAL INTELLIGENCE (AI)

I understand that Pathways utilizes an electronic health record to document the services I receive and that an AI-assisted tool may be used during my sessions to help with documentation. Privacy and confidentiality is a top priority. The AI tool is used in compliance with HIPAA regulations and does not store or use your information for any purpose outside of your care. I give my permission for this tool to be used, knowing that my provider will always oversee and control the final documentation. I understand that I may withdraw my consent at any time without affecting the care I receive. ❑Yes ❑No

EMERGENCY MEDICAL AUTHORIZATION

I, the undersigned, do hereby authorize Pathways, Inc. and its agents or representatives to consent, on my behalf, to any emergency medical/hospital care or treatment to be rendered upon the advice of any licensed physician. I agree to be responsible for all necessary charges incurred by any hospitalization or treatment rendered pursuant to this authorization.

CONSUMER CONFIDENTIALITY STATEMENT

As a consumer of services provided by Pathways, Inc., I understand that the identity of other consumers is confidential. I understand that Federal Law and regulations protect the confidentiality of each individual who receives services from Pathways, Inc.

I will respect other consumers' confidentiality. I understand that if I obtain information regarding another consumer, including but not limited to, the fact that an individual is being treated at Pathways; and/or, if while attending a group service, should I learn any additional information regarding an individual, I cannot discuss this outside of the program.

I understand that there could be penalties for failure to comply with the above statements, including possible civil penalties.

PATHWAYS CONFIDENTIALTY STATEMENT

In general, the privacy of all communications between a consumer and Pathways is protected by law, and Pathways can only release information about our work to others with written permission; however, there are a few exceptions.

- In most legal proceedings, you have the right to refuse permission for Pathways to provide any information about your treatment. However, in some proceedings, such as child custody and others in which your emotional condition is an important issue, a judge may order testimony from a Pathways employee, in which case we will comply with the order.
- There are some situations in which Pathways is legally obligated to take action to protect others from harm, even if we have to reveal some information about your treatment. For example, if we believe that a child, elderly person, or disabled person is being abused, we must file a report with the appropriate state agency.

- If Pathways believes that you are threatening serious bodily harm to another, we are required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for you. If you threaten to harm yourself, we may be obligated to seek hospitalization for you or to contact family members or others who can help provide protection. If a situation like this occurs, we will make every effort to fully discuss it with you before taking any action.
- Pathways professionals function from an Interdisciplinary team approach and consult with each other regarding the treatment of consumers. All employees of Pathways are legally bound to keep the information confidential.

If you have not received services within 180 days, your record will be closed. Should you need services in the future, we would be happy to serve you. You will be reassessed at that time.

SIGNATURES:

I have read, understand, and consent to the above:

Signature of Consumer: _____ Date: ____/____/____

Authorized Representative/Guardian: _____ Date: ____/____/____

Pathways Witness: _____ Date: ____/____/____